History & Physical
11/18/2007

Chief Complaint: Blood in urine

History of Present Illness: Patient is a 75-year-old female recently diagnosed with a mass in her bladder who complains that yesterday evening she had increased blood in her urine throughout the night, and it greatly increased in nature.

Past Medical History: Past medical history includes recently diagnosed bladder mass, urinary tract infection, hypertension, anxiety, depression, hysterectomy, tonsillectomy, bilateral bunion surgery, and pneumonia.

Allergies: Iodine

Medications:
1. Lisinopril 20 mg b.i.d.
2. Valium 5 mg daily PRN

Social History: She smokes tobacco, and drinks alcohol

Family History: Unknown

Review of Systems:
She denies visual or hearing change, chest pain, and shortness of breath, nausea, vomiting, diarrhea, constipation or lower extremity edema.

Physical Examination:
Vital Signs: T: 96.2 degrees. HEART RATE: 74. R: 18. BP: 159/79
Oxygen saturation is 94% on room air
HEENT: Tympanic membranes are intact and clear. Throat is clear.
Neck: No jugular venous distention or lymphadenopathy
Lungs: Clear to auscultation bilaterally
Cardiac: Regular rhythm
Abdomen: Mildly distended, and mildly tender in the suprapubic area
Extremities: No edema

Laboratory Data: Hemoglobin is 13.6, white blood cell count 10.7, and platelet count 385,000. INR is 1.1. Sodium is 143, potassium 3.7, chloride 105, CO2 23, and glucose 114. BUN is 19, and creatinine 1.0. Urinalysis with large occult blood, moderate leukocytes, positive nitrate, red blood cells massive, white blood cells 41-50, and bacteria 1-10.

Radiographic Data: Recent CT abdomen evaluation revealed right hydronephrosis, and bladder mass.

Assessment and Plan:
1. Hematuria secondary to bladder mass. She has currently been evaluated by urology. She is undergoing bladder care, and surgery is planned for Monday.
2. Urinary tract infection, on Rocephin
3. Hypertension
4. Anxiety and depression

Signed: Internal Medicine Doctor

Consultation
11/18/2007

Chief Complaint: Hematuria

History of Present Illness: This 75-year-old white female has, for about three months, had irritating urinary symptoms and microscopic hematuria, occasional intermittent gross hematuria. It is felt that she had a urinary tract infection. She had been treated with antibiotics several times. This seemed to clear things up and then they recurred. During the course of her evaluation she had a CT scan, which I have reviewed but I have not seen the report but it shows a significant right-sided hydronephrosis down to the bladder and a small, possibly partially calcified mass within the bladder in the general location of the ureteral orifice. The bladder also appears to be filled but she relates she was told not to void during the procedure and that she needed to. She was to have had an office visit with my partner this afternoon but developed severe bleeding over the last day and was seen in the Emergency Room today and admitted.

Laboratory studies are not available but she was told that her hemoglobin and hematocrit were okay. She relates that she is voiding all right although it looks quite bloody and she has had to get up a lot during the night and has frequency during the day. She was also feeling weak, although feels better presently.

Past Medical History: She has had hypertension

Medications: Lisinopril. She has also taken Valium.

Allergies: Iodine. She did have a contrast CT but was given prednisone before receiving it and did not have a problem with it.

Social History: She smokes approximately a pack a day and drinks socially

She has had some lower lumbar aching. There are no acute complaints within the review-of-systems and the ER review-of-systems has been reviewed.

Physical Examination:
General Appearance: This is an elderly white female in no acute distress, WDWN
Vital Signs: BP: 174/88. P: 94. R: 18.
HEENT: No gross pathology
Respiratory: No respiratory difficulty
Abdomen: No tenderness to bilateral CVA fist percussion. Abdomen is soft and nontender without mass or organomegaly.
Extremities: Without edema. No obvious skin lesions.

Impression: Bladder lesion with ureteral obstruction, hydronephrosis and hematuria

Disposition: Will plan to continue support. Plan to start IV antibiotic, follow-up the degree of hematuria with three-bottle collection and do catheter irrigation if it appears indicated and/or there is a large residual. The patient is scheduled for a procedure by my partner on Monday, which would consist of mostly likely resection of the lesion and attempt at opening up the ureter with possible stent placement. Will plan to follow her over the weekend. Thanks for asking us to consult.
Signed: Urologist #1

Operative Report
11/21/2007

Preoperative Diagnosis: Bladder tumor, gross hematuria

Postoperative Diagnosis: Bladder tumor, gross hematuria

Procedures:
1. Transurethral resection of bladder tumor
2. Left retrograde pyelogram

Anesthesia: General

Indications: This is a 75-year-old female with gross hematuria. CT scan shows she had a mass at the base of her bladder and hydronephrosis on the right side. After options were discussed, she understand that she would undergo TURBT, and there was a possibility we may have to put in stents in the right side. However, we may not even be able to find an opening on the right side. She understood other potential risks and complications.

Findings: Large bladder tumor at the base of her bladder. The right UO was never identified. Left retrograde pyelogram was negative. A three way, 24-French Foley catheter was placed with a C guide port plug. The patient will need right nephrostomy tube placement.

Procedure: After informed consent was obtained, the patient came to the operative suite where she was placed in the dorsal lithotomy position. Under general anesthetic, the area of her genitalia was prepped and draped in a standard fashion. A 21-French ureteroscope was placed per urethra into the bladder. The bladder was surveyed showing a large bladder tumor at the right base. It was very nodular and sessile in nature with a very wide base. The right UO was completely not obliterated by this mass. I could not see any signs of the UO. The left UO looked normal. Retrograde on that side was grossly normal. The patient was given indigo carmine, and blue efflux was seen from the left side, but the right side we never saw anything blue. A 26-French resectoscope sheath was advanced in the bladder. A loop was then used to resect the large tumor. It had a very wide base. Deep margins were taken of it. Despite resecting the right base of the bladder, there was no sign of any UO. A wire was used with the tiger tail to try to cannulate any potential openings, but no sign of any UO was seen. Therefore, the base was inspected again. Again, no sign of any blue was seen coming out, even though the left UO continued to show signs of blue urine. The base was cauterized for any bleeding. Excellent hemostasis was seen. The scope was withdrawn. A 24-French, three way catheter was placed without difficulty. Ten mL was inflated into the balloon. The catheter was irrigated and working well. Urine was clear in color. The C guide port was then plugged and was just put to dependent drain. The patient was taken to the recovery room in stable condition.

Plan: We will set her up for right nephrostomy tube placement and antegrade nephrostogram.

Signed: Urologist #2

Pathology Report
11/21/2007

Clinical Information: Bladder mass and hydronephrosis

Specimen:
1 Bladder tumor
2 Bladder tumor, deep margin

Gross Description:
Specimen #1 consists of 6 grams of tissue. The specimen is submitted in toto in Cassettes 1A through 1D.
Specimen #2 consists of 1 grams of tissue. The specimen is submitted in Cassette 2A.

Final Diagnosis:
1) Bladder tumor: High grade urothelial carcinoma (grade 3 out of 3) with smooth muscle invasion.
2) Bladder tumor, deep margin: Fragment of grade 3 out of 3 urothelial carcinoma with adjacent coagulation artifact and fragments of fibrovascular tissue and smooth muscle with chronic inflammation and fibrosis and coagulation artifact.

Specimen Type: Transurethral resection
Tumor Size: Cannot be determined
Histologic Type: Urothelial carcinoma
Associated Epithelial Lesions: None identified.
Histologic Grade: High grade
Primary Tumor: pT2
Regional lymph nodes: pNx
Distant metastasis: pMX
Margins: Cannot be assessed

Radiology Report
11/21/2007

Clinical Indication: Bladder Tumor

Three images were acquired during retrograde pyelogram by the urologist. The left ureter is injected. There is an area of kinking. There is incomplete distention of the renal collecting system. No obvious filling defects are noted.

Area of kinking in the mid left ureter without obvious filling defect.

Radiology Report
11/22/2007

Ultrasound Guided Right Percutaneous Nephrostomy

Clinical Indication: Obstruction

Ultrasound was performed over the kidney to identify the right hydronephrosis. The area was prepped in a sterile fashion. Using Xylocaine for local anesthesia, a 20 G needle was advanced into the collecting system under direct ultrasound guidance. The guidewire was placed in the right ureter with subsequent passage of progressive dilators with subsequent positioning of an 8 F nephrostomy catheter which was formed in the collecting system. Attempts to place a guidewire through the right ureter were unsuccessful due to prominent dilatation and prominent tortuosity. The catheter was sutured with Prolene sutures. The patient tolerated the procedure well. There were no complications.

Successful ultrasound guided percutaneous nephrostomy tube placement.

Medical Oncology Consultation
11/23/2007

History of Present Illness: Patient is a 75-year-old who is admitted with severe hematuria. She had been having hematuria periodically through the fall and had been treated with antibiotics with good relief. She then had persistent changes and a CT of the abdomen showed right hydronephrosis. She was referred to urology, but before that appointment could be accomplished she presented to the Emergency Room with severe bleeding. She is status post a TURBT with a finding of a high grade transitional cell carcinoma invading into the muscle. That path report was heard on the dictation service as I do not find a hard copy of the report on the chart at this time. The patient has no prior history of bladder problems. She has a history of hypertension. She is status post total abdominal hysterectomy, bilateral salpingo-oophorectomy, although her cervix is still in place, in 1960 for benign uterine fibroids. No history of heart attack or stroke, no peptic ulcer disease or diabetes mellitus. She is single. She has a daughter who I have cared for with breast cancer, who is at this time is alive and well.

Family History: Notable for father who died of heart disease in his 60's. Mother died of breast cancer and a maternal aunt also had breast cancer, but survived. A sister died of a postop myocardial infarction. She worked at a law firm with no known exposures to toxins or chemicals. She does smoke and drinks alcohol.

Review of Systems: No headache, no increased cough, hemoptysis, chest pain or shortness of air, no nausea and vomiting or unexplained weight loss and no new sites of bony pain.

Physical Examination:
General Description: She is alert and oriented, in no acute distress.
Vital Signs: 60.1 kilos and is 157 centimeters tall. T: 96.8, P: 95, R:
18, BP: 136/84.
HEENT: No icterus or jaundice. Pupils are equal and reactive to light, no oral lesions, no palpable cervical supraclavicular, infraclavicular or axillary nodes.
Heart: Regular, with no murmur or gallop.
Lungs: Showed distant breath sounds, but no rales or wheezes.
Abdomen: Soft, nontender. She has no hepatosplenomegaly or ascites, no inguinal adenopathy.
Extremities: No lower extremity edema, cyanosis or clubbing. She has a percutaneous nephrostomy in the right flank.

Laboratory Data: Hemoglobin 10, creatinine is 1. Coags normal. Alkaline phosphatase normal. Calcium slightly low. Chest x-ray negative for metastasis.

Assessment and Plan: High grade transitional cell carcinoma involving the muscle. The right ureteral junction is obstructed by the tumor. As such, I think this patient would be a poor candidate for an attempt at bladder sparing as it would require sacrifice of the right kidney. I have recommended to the patient that she undergo radical cystectomy with an ileo-conduit. Adjuvant therapy can certainly be considered, however, the data is shaky as to whether that truly benefits patients even with high risk disease. I explained to the patient with muscle invasion cure rate with surgery alone was about 50%, but short of surgery, she would not be expected to be cured of her disease. I advised her to stop smoking at least prior to the expected anesthesia. Her and her daughter and her friend's questions were answered today.
Signed: Medical Oncologist

Discharge Summary

Discharge Date: 11/25/2007

Hospital Course: The patient is a 75-year-old female admitted with gross hematuria. She recently was diagnosed with a mass in her bladder. She was evaluated by urology on November 21, 2007. She was taken to surgery for a transurethral resection of bladder tumor. A bladder tumor was found at the right base. Biopsy was done and she was scheduled for a right nephrostomy tube. This was placed on November 22, 2007. Ultimately, the patient was diagnosed with a high grade transitional cell carcinoma involving the muscle. She was evaluated by Medical Oncology during her stay with the assessment that the right ureteral junction was obstructed by the tumor. It was felt that she would be a poor candidate for bladder sparing, as it would require sacrifice of the right kidney. Thus, it was recommended to her that she undergo a radical cystectomy with an ileal conduit, and then consideration of adjuvant therapy post this surgery. The patient was in agreement with this assessment and recommendation.

She will be discharged to home with planned surgical followup.

Disposition: Discharge to home

Activity Instructions: Activity as tolerated

Diet Instructions: Regular

Followup Instructions: Followup with Urology in one week, and Home Health for general concerns and nephrostomy tube care.

Discharge Medications:
1. Flonase two sprays each nostril daily
2. Lisinopril 20 mg b.i.d.
3. Nicotine patch
4. Ciprofloxacin 250 mg b.i.d. for one week
5. Darvocet-N 100 one to two q.4-6 hours p.r.n. for pain

Discharge Diagnoses:
1. High grade transitional cell carcinoma of the bladder
2. Hypertension

Signed: Internal Medicine Doctor

Radiology Report
01/06/2008

CT Abdomen and Pelvis w/o Contrast

Clinical Indication: Patient hypotensive, history of bladder cancer

Discussion: An emergent CT scan is performed on 1-16-08 at 0155 pm. Multiple 7.5 mm interval scans performed from the epigastric region to the bladder. Oral contrast is given to opacify the gastrointestinal tract. Intravenous contrast is not given as the patient relates an iodine allergy history.

There are no previous films available for comparison.

There is mild discoid atelectasis in the anterior left lower lung field. No area of consolidation or pleural fluid seen.

The liver and spleen are normal in size and contour as is the pancreas. No calcified gallstones are seen. There is a percutaneous nephrostomy catheter in place on the right. There is no hydronephrosis present on the right at this time. The pelvocalyceal system has been decompressed by the nephrostomy catheter. There is air and contrast scattered through the small and large bowel which does not appear to be particularly distended. There are some scattered air fluid levels in the small bowel, the finding is nonspecific at this time as the bowel does not appear to be distended or obstructed. Follow-up plain films may be of value. The bladder is distended with urine. There appears to be a solid abnormality involving the anterior aspect of the bladder just to the left of midline, a second mural nodule involving the posterior and right lateral side of the bladder. This may reflect the patient's known bladder carcinoma. Uterus is not identified and I assume this has been resected. There is sigmoid diverticulosis. There is some minor scattered plaque in the aorta. There is scattered spurring in the lumbar vertebral bodies.

Distended gallbladder. Percutaneous nephrostomy catheter in place on the right, no residual hydronephrosis at this time. Scattered plaque in the aorta. Nonspecific gas pattern.

Apparent mural nodules involving the bladder wall most likely reflecting this patient's known bladder carcinoma.

There is a vacuum phenomenon present in the lumbar spine region with air in the region of the left neural foramen suggesting a lateral disc herniation, this apparently is at the L4-5 level.

History & Physical
02/01/2008

Chief Complaint: Invasive bladder cancer

History of Present Illness: This is a 75-year-old female with invasive bladder cancer. She had muscle-invasive disease, found on transurethral resection of bladder tumor on November 18, 2007. She was already on the schedule for surgery in December and was admitted for bowel prep and medical evaluation, when it was noted that she had pulmonary issues and was noted to have pneumonia. Therefore her surgery was cancelled at that time. She was in the hospital for the pneumonia and was found to have obstructive pulmonary disease. Afterwards she did fine and then was admitted to the hospital again in January, with a bout of infection from her nephrostomy tube. She had nephrostomy tube placed for obstruction of her right kidney, due to her bladder cancer. She notes at this point she has been doing fine. She states she is breathing fine without difficulty. No signs of any phlegm, fevers, or chills. No shortness of breath. No chest pain. She feels like she is ready for surgery.

Allergies: Iodine

Medications: Include:
1. Valium 5 mg p.r.n.
2. Vicodin p.r.n.
3. Cipro
4. NicoDerm patch

Past Medical History: Bladder cancer per history of present illness. Hypertension. Clostridium difficile toxin. Pneumonia. Pulmonary disease. Anxiety/depression. Nephrostomy tube placement.

Social History: Smokes tobacco, is in the process of quitting. Drinks alcohol.

Family History: Unknown

Review of Systems: As per history of present illness

Physical Examination:
Vital Signs: T: 96.1. BP: 140/81. HEART RATE: 74.
General: Sitting down, in no apparent distress
HEENT: Normocephalic, atraumatic
Neck: Supple
Chest: Unlabored breathing
Abdomen: Soft. Conduit site is marked
Extremities: No cyanosis

Assessment: Muscle-invasive bladder cancer with obstruction of the right kidney

Plan: Radical cystectomy with ileal conduit

Signed: Urologist

Operative Report
02/02/2008

Preoperative Diagnosis: Invasive bladder cancer, right hydronephrosis

Postoperative Diagnosis: Invasive bladder cancer, right hydronephrosis

Procedures:
1. Radical cystectomy with ileal conduit
2. Bilateral pelvic lymph node dissection

Anesthesia: General

Indications: This is a 75-year-old female with invasive bladder cancer. She has also had right hydronephrosis and had a nephrostomy tube placed. She had muscle invasive cancer and is to undergo radical cystectomy. She had some medical issues that had to be resolved prior to surgery.

Procedure: After informed consent was obtained, the patient was taken to the operating suite where she was placed in the low dorsal lithotomy position. Her genitalia and her abdomen were prepped and draped in a standard fashion. A 20 French Foley catheter was placed on the field sterilely. She had a previous low midline incision. Her low midline scar was excised, going from her pubic bone just short of her umbilicus. The fascia was then identified and was divided. Once we got to the fascia there was noted to be quite a bit of scar tissue from her previous surgery and we used scissors and pick ups to enter the peritoneal cavity. There were noted to be quite a bit of adhesions at the midline. We had to take a lot of these sharply down with scissors. Once we had some of the omentum that was stuck against the anterior abdominal wall cleared off, the urachus was identified and the space of Retzius was opened up. We went out laterally along the urachal remnants freeing up the bladder laterally there. There were some adhesions along the peritoneal reflection with the colon. That was taken down as well. Once these adhesions were all taken care of, a Bookwalter was placed and all the bowel contents were packed out of the way and retractors were put in position. Going out laterally to the right side, we went all the way down and went into the right pelvic space. She has had a previous hysterectomy. Reflecting and peeling back along the peritoneal reflection posteriorly, we encountered the right ureter. The ureter was very dilated on that right side and we dissected down distally until we encountered where it entered the bladder. It was clipped at this point and divided and a piece was sent out for frozen section. This was negative for any malignancy.

The right superior vesicle was identified, hemolocked and divided. We then went on to the left side and identified the left ureter. This was dissected out, clipped and divided. A piece of that was sent off for frozen section and that was negative for any cancer there as well. The left superior vesicle artery on the left side was also identified, hemolocked and divided. We then lifted up on the lateral pedicle on that right side and then a reticulating arm GIA was then used to fire across that lateral pedicle, freeing it up. We went along the left side and did the same thing. Going along the endopelvic fascia on the right and left, this was incised with the cautery exposing out the lateral side walls of where the vaginal wall and where the urethra was. There was some bleeding coming from the dorsal vein complex and 0-Vicryl suture was used to

maintain hemostasis with that. We then teased a plane between the vagina, starting at the bladder neck. We did have a sponge stick in the vagina to help identify it. The vagina was very adherent to the bladder, especially posteriorly along the base of the bladder. Therefore the vagina was entered here and then we left a remnant of the vagina and anterior vaginal wall against the bladder so that we would get an adequate margin. We went toward the apex and got that freed off and then we worked our way around and were able to start peeling the bladder off the vagina. Once we got around the base of the bladder where it is attached.

Going along the urethra, we divided and exposed the urethra as far distally as possibly as we were able to get a right angle underneath the urethra between the bladder and the urethra. The urethra was then divided using the cautery going as distal as possible. Once the catheter was exposed, the catheter was brought into the field and we divided the posterior layer of the urethra. We were able to pull out on the balloon and divide a plane between the urethra and the vagina, peeling that off. On that left side we did fire the articulating arm GIA to help free up the left lateral pedicle as well too. As we were able to do this, we kind of teased back and forth, working our way off of the vagina laterally. Once we were able to do this again and we again had cut out a piece of the vagina that was adherent to the base of the bladder, the specimen came out intact. We noted that we had nice margins around; no obvious gross signs of any cancer growing outwardly. We had a defect in the vagina there and we could clearly see where the sponge stick was. The rectum was out of harm's way. The vaginal defect was closed with a running 0-Vicryl suture and then the wound was copiously irrigated showing that we had good hemostasis. We did lose some blood again during various parts of the cystectomy. Once this was complete, we checked our area for any bleeding. Cautery was used to stop any bleeding and then we placed some fibrillary over some of the more raw surface areas and a lap sponge was used to pack off the area. After this was done, good hemostasis was seen on the pedicle areas and in the pelvis.

Pelvic lymph node dissection was taken. This was an extended version going out just lateral to the artery and going along the vessels to the pelvis side wall, preserving the obturator and nerve and then going proximally to the bifurcation and above a little bit. This was done with a combination of blunt and sharp dissection with clips and cautery. The right specimen came out intact and was sent off for permanent section. In likewise fashion, the left pelvic lymph node dissection was also carried out in the same fashion using the same boundaries as mentioned above and the same technique. This was also sent off for permanent analysis and nothing remarkable was seen there. Both sides were inspected and no signs of any bleeding were seen. Excellent hemostasis was noted. The left ureter was then tunneled underneath the sigmoid colon and then brought over into the right side parallel to the right ureter. The terminal ileum was then identified. We looked at the colon and saw that the patient had a previous appendectomy and then the terminal ileum was traced out and we were at least 15-cm away from the terminal ileum and we found a nice segment of loop of ileum that we would use for a conduit. We inspected the mesentery and then were able to divide the mesentery using the LigaSure to corresponding places on her bowel that we had preplaced with silk sutures. We then used a GIA stapler to divide the bowel at both ends, taking a segment of ileum out of continuity. The ileum was restored by doing a side to side anastomosis using the GIA to staple doing a side by side and then the opening defect was closed with the TA55; 3-0 silk was then placed at the crotch of our anastomosis to help secure that anastomosis there. The defect in the mesentery was closed with interrupted 3-0 silk sutures. The piece of ileum was then opened up on the stoma side and was

irrigated copiously to clear it out. It was actually very clean and the patient did a very nice job with the bowel prep. There was just some mucous and succus noted but very minimal.

Using the butt end of our conduit, a small hole was made in it using pickups and Metzenbaum scissors and once the hole was identified, an anastomosis was made to our left ureter. The left ureter had nicely dilated in the meantime as we had it clipped. The clip was removed and the ureter was spatulated and anastomosis was done in a Bricker's style using interrupted 2-0 chromics. The right ureter was then implanted to the ileal conduit going a little bit more distally along the conduit and in the same fashion, making an opening in the conduit. This time we had to make our hole in the conduit just below that bigger because that right ureter was again quite distended from her previous obstruction. The ureter was spatulated and then an interrupted anastomosis was done using 4-0 chromic in the same fashion. During the anastomosis, diversion stents were placed in both ureters. The butt end of the conduit was then tacked down with a piece of peritoneal reflection to secure it and so that the anastomosis would be in the retroperitoneal fascia. The premarked stoma site was identified, grasped with a Kocher and then a knife was used to cut a circle in the skin. A core of fat was cauterized out and the fascia was identified. A cruciate incision was made through the fascia. A muscle splitting procedure was done on the rectus abdomini muscle and then the posterior fascia was also incised and with the cautery, making an opening into the abdominal wall; 3-0 chromic was preplaced into the four crotches of our cruciate. The stent and conduit was then brought out through the opening for our stoma. Please note that the ileum was placed in its normal orientation so that the peristalsis would go outwardly. The preplaced sutures were then used to secure the conduit to the fascia level and then everting rosebud technique was used where we used some 3-0 Vicryl to evert the end of the stoma and then some in between sutures were placed to close off the skin around the stoma. We had a nice rosebud eversion noted and the conduit was nice and pink there. Two drains were then placed through stab incisions in the right and left side and one was placed in the pelvis and one along the right gutter. The omentum was brought down to cover the wound and then the fascia was closed with a running #1 looped PDS. The knot was buried with 2-0 plain gut. The skin was closed with staples. The conduit was nice and pink and a bag was placed over it with the diversion stents in place. The drains were put to bulb suction. The patient tolerated the procedure well and was sent to the recovery room in stable condition.

Signed: Urologist

Pathology Report
02/02/2008

Clinical Information: Muscle - invasive bladder cancer with obstruction of right kidney

Specimen:
1 Right distal ureteral margin
2 Left distal ureteral margin
3 Urinary bladder
4 Right pelvic lymph nodes
5 Left pelvic lymph nodes

Intraoperative Consult:
Frozen Section: 1) No tumor seen
Frozen Section: 2) No tumor seen

Gross Description:
Specimen #1 consists of a segment of ureter measuring 0.4 cm in diameter. The specimen is submitted for frozen sectioning and is then placed in Cassette 1FS for permanent sections.

Specimen #2 consists of a segment of ureter measuring 0.4 cm in diameter. The specimen is submitted for frozen sectioning and is then placed in Cassette 2FS for permanent sections.

Specimen #3 consists of a female urinary bladder resection measuring 10 x 7 x 5 cm. The posterior wall shows a fairly well circumscribed mucosal nodule measuring 3.2 x 2.8 x 1.6 cm. Grossly, the lesion invades through the wall. The attached included section of vagina measures 2 x 1 x 1.5 cm. The bilateral ureters are grossly uninvolved by frozen section (See Specimen #1 and #2). The distal urethral resection margin is submitted en face in Cassette 3A. Sections of the tumor are submitted in Cassettes 3B through 3D. Sections of the cervix are submitted in Cassette 3E. Sections of the uterus are submitted in Cassettes 1F and 1G.

Specimen #4 consists of irregular adipose tissue measuring 8 x 4 x 1 cm. One lymph node is submitted in Cassette 4A. One lymph node is submitted in Cassettes 4B through 4D.

Specimen #5 consists of an irregular fragment of adipose tissue measuring 7 x 4 x 1.3 cm. One lymph node is submitted in Cassette 5A. One lymph node is submitted in Cassette 5B and one lymph node is submitted in Cassette 5C.

Final Diagnosis:
1) Distal Ureter, Right: No tumor.
2) Distal Ureter, Left: No tumor.
3) Urinary Bladder, Cystectomy: Poorly differentiated urothelial carcinoma, 3.2 cm in maximum dimension involving perivesicle tissue. Margins are free of tumor. See CAP checklist. Section of vagina: No histopathologic abnormalities.
4) Lymph Nodes, Right Pelvic: Lymph nodal tissue with no evidence of metastatic tumor.
5) Lymph Nodes, Left Pelvic: Lymph nodal tissue with no evidence of metastatic tumor.

Specimen Type: Total cystectomy
Tumor Site: Posterior wall
Tumor Size: 3.2 cm in greatest dimension
Histologic Type: Urothelial carcinoma
Histologic Grade: High grade
Pathologic Staging:
Primary tumor: pT3b, macroscopically (extravesicular mass)
Regional lymph nodes: pN0
Distant metastasis: pMX
Margins: Uninvolved by invasive carcinoma

Medical Oncology Consultation
02/08/2008

Patient is a 75-year-old with invasive bladder cancer, who is now status post radical cystectomy. Her history began several months ago when she presented with hematuria and was found to have invasive bladder cancer. She was scheduled for surgery earlier, but developed severe pneumonia with an Intensive Care Unit stay, and has required a recovery from that before proceeding with definitive surgery. She has comorbid illnesses of hypertension, tobacco use, chronic obstructive pulmonary disease, a history of anxiety and depression, Clostridium difficile enterocolitis during her pneumonia hospitalization, and prior surgery of a tonsillectomy.

Allergies: Iodine

She was maintained on vitamin C, ciprofloxacin, Valium, Lexapro, lisinopril, Flagyl, multivitamin, NicoDerm patch, Vicodin and albuterol at the time of her admission.

She is trying to quit smoking, but has a lifelong history of one to two packs a day, and drinks alcohol regularly. She is single. Her daughter is attentive to her and provides her cares.

Physical Examination:
In General: She is alert and in no acute distress.
Vital Signs: WT: 57.9 kilograms. T: Has gotten up to 102.6 this morning. P: 122. R: 18. BP: 119/58.
HEENT: There is no icterus or jaundice. No oral mucositis.
Lymph Nodes: No nodes in her neck.
Heart: Regular, but somewhat tachycardic.
Lungs: Show decreased breath sounds at the bases.
Abdomen: Not examined because of recent surgery.
Extremities: She has no edema.

Laboratory Data: Her white count is elevated at 16.2 and she is lift-shifted with 77 segs, 5 bands, hemoglobin 9.9 and platelets 462.
Creatinine is 0.7. Albumin is low at 1.6.

Pathology has revealed a poorly differentiated urothelial carcinoma, 3.2 centimeters in size, going through to the perivesical tissue. A number of lymph nodes obtained are not noted on the pathologist's report, but they are reported as all negative. She was staged preoperatively and had no evidence of widespread metastatic disease. As such, she has T3N0M0 Stage III. This would portend a 50% recurrence risk after surgery alone; however, multiple randomized trials and adjuvant therapy in bladder cancer have not been conclusive as to whether there is benefit. The only positive trial was the M. D. Anderson trial utilizing NVAC and that has not been borne out and other trials tried to confirm that finding. As such, at this point, the standard of care is no additional treatment or enrollment in a clinical trial. We do not have any trials open for resected Stage III bladder cancer at this time. As such, I would recommend postop recovery with no plans for additional treatment. I would be happy to follow her alone, watching for any signs of disease recurrence. I will come back tomorrow and see if she and her daughter have any other questions. Thank you for letting me know she was back in.

Signed: Medical Oncologist

Discharge Summary

Final Diagnoses:
1. Transitional cell carcinoma of the bladder
2. Hypertension
3. Wound infection
4. Diarrhea
5. Depression
6. Reactive thrombocytosis
7. Chronic obstructive pulmonary disease

Procedures: Radical cystectomy with ileal conduit

Consultants: Internal Medicine, Infectious Disease, Medical Oncology

Hospital Course: Refer to H&P. The patient underwent a successful radical cystectomy and ileal conduit. She had a couple of drains in place and a conduit was put with dependent drain with uro-diversion stents inside. She was sent to the ICU for close monitoring. Internal Medicine was consulted in following her as well. She was admitted the day prior to surgery for antibiotics and bowel prep. She has had previous issues with COPD, pneumonia and urinary tract infections. She was in the ICU until she was noted to be more stable and then was transferred to telemetry. She had an NG tube initially and that was discontinued but she was kept n.p.o. After she was on telemetry and she was noted to be stable, she was sent to a regular hospital bed. She was followed closely for hypertension and COPD. She had minimal drain output and then those drains were removed. She had an epidural for pain control and that was removed and she was switched to p.o. pain medications. She started passing some gas. She did have stage III high-grade cancer and an oncology consult was done. Med Onc doctor felt that she would not necessarily benefit from an adjuvant therapy since all her excisional margins were negative as well as her lymph node disease negative. She developed some fever around postoperative day #5 and infectious disease consult was performed and she did have some signs of redness of her wound consistent with a wound infection. The cellulitis, however, started resolving on its own and the staples were removed and she did have a little bit of opening of her incision site but no pus per se. The wound was packed and she did get an ultrasound that showed no fluid collection. After the wound was being packed, it was noted that the tissue was granulating. She did note that when she would walk around, she would pass some fluid down per vagina and even had an episode of blood that was self-limiting. She was having some serous drainage down below which we were not surprised that she had. We did have to close her vaginal wall with the cystectomy and she noticed that the amount coming down was less and less. Her wound infection started to nicely improve. Her white count has now normalized. She was noted to have a high platelet count and oncology saw her again and noted to have reactive thrombocytosis. She did develop some diarrhea and cultures are being sent off for C. difficile. Physical therapy and occupational therapy were also consulted to help with her conditioning and it is felt at this point that she is medically stable to discharge her from inpatient status but that she would need some kind of skilled nursing. She did qualify for skilled nursing criteria and she will be discharged and admitted to skilled nursing under her internist.

Signed: Urologist